



# Patient Registration

Title: ..... Surname: ..... First Name: .....

Address: .....

.....

Phone: (H) ..... (W) .....

(Mobile) .....

Email: .....

Date of Birth: ..... Occupation: .....

Parent/ Guardian (if patient is a child): .....

GP's Name: .....

GP's Address: .....

Medicare No.: ..... Ref. on card:.....Expiry:.....

Health Fund: .....Member No.: .....

DVA File No.: (if applicable) .....

How did you hear about us (please tick the appropriate circle) ?

GP  Healthcare Professional  Word of mouth  Internet  Other

I hereby give express permission to the members of the Norwest ENT Group to receive and supply personal medical information from or to other medical practitioners on my behalf. I/we acknowledge that I/we are wholly responsible to arrange any further appointments to discuss test results conducted by our doctors on our behalf. Please note that your private information will be protected under the Commonwealth Health Privacy Act 2001.

Signature:.....

Thank you. Could you please hand this form back to the receptionist.